The Caregiver's Notebook

A Guide for Organizing and Record Keeping

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617-926-4100 www.springwell.com

Dear Caregiver,

Welcome to the Springwell Caregiver's Notebook!

The goal of this Notebook is to have a central place for you to record and document the important aspects of your loved one's care. This includes:

- Critical At A Glance Information
- A Calendar for Schedule Tracking
- Care Providers
- Daily Routine and Care information
- Medication Information
- Health Information and Medical Events
- Medical Professional Contacts

Because it is easy to forget details from conversations and important next steps, we have included a Call Log section for tracking telephone calls and notes from medical appointments.

We have also included a section for legal, financial and insurance information. Since this information is confidential, we suggest the section be removed and stored in a safe place.

The Notebook is intended to be comprehensive. Some sections may not be immediately relevant. As you fill it in, it will help you be prepared when the need for the information arises.

Since information changes, use a pencil when filling out some of the forms (e.g., Medications). For your convenience, extra copies of the forms are available to download from our website, **www.springwell.com.**

Our telephone number and website is included on every page. Please call us with your questions and concerns. We are here to help you on your caregiving journey.

Making the most of this Organizational Tool

There is no question that filling out each line in this book can feel overwhelming. Because it was designed to be a launching point for being a better informed and organized Caregiver, it covers a wide range of information and details. Keep in mind you don't need to complete every line in each section. Use this as your framework for gathering and organizing information.

Here are some tips on how to make the most of this Notebook:

- Pace yourself by choosing the pages and sections that are most relevant now, and start there.
- As much as possible, involve your loved one in completing the information. It will provide the opportunity for discussion and may also provide a sense of control during a time when control may seem fleeting to them.
- As with caregiving, don't 'go it alone'. Enlist family members and others close to the elder to help complete a page or an entire section.
- Since this tool is a 3 ring binder, you can customize it. Rearrange the sections to fit your organizational style. Decide which sections you want to have at the ready, which sections should stay at the elder's home and which sections should be removed to be stored in a safe place.
- To make certain pages portable, we suggest removing and storing them in a separate "travel" binder.
- Photocopy important papers to put into the binder while keeping the original in a safe place.
- Use colored Post-It Note flags to alert a family member, friend or other caregiver on any important changes or additions in the Notebook.
- Don't limit the use of the Calendar to remembering medical appointments. Use it as a tracking system for calls to make, medication changes, when a prescription needs to be refilled, etc.
- Gathering financial information can be a daunting task. Collecting one month's worth of mail will give you a snapshot of existing bills and financial statements (except for those that come quarterly). The most recent tax return is another good source of financial information. Remember, it is always best to ask permission to access any type of financial records.
- Most importantly, use the Springwell Caregiver Program as your caregiving resource. A Caregiver Advisor can guide you on personalizing this tool to fit your caregiving needs. If you need suggestions on how to gather important information or broach a subject with a loved one, call us. A Caregiver Advisor is available to speak to in person as well as by phone and email to provide you with information and resources.

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Notebook Contents

Critical Information

Name _____ Date of Birth _____

Address _____ Phone _____

Emergency Contact	**Nearest Relative, Friend/Neighbor**
Name	Name
Relationship	Relationship
Contact Instructions	Contact Instructions
Home Ph	Home Ph
Work Ph	Work Ph
Cell Ph	Cell Ph

Special Health/Medical Conditions and Instructions

_____

_____

_____

_____

Known Allergies

Medications _____ Food _____

Dietary Restrictions _____ Daily Fluid Intake _____

Baseline: Blood Pressure _____ Blood Sugar _____ Weight _____ Blood Type _____

Medical Care

Primary Care Doctor _____ Phone # _____

Hospital _____ Phone # _____

Specialty Doctor _____ Phone # _____

Health Insurance

Primary Plan _____ ID/Subscriber # _____ Phone # _____

Supplemental _____ ID/Subscriber # _____ Phone # _____

Declared Emergency Medical Instructions

Include the name and location of any written documentation of emergency care wishes. For example, Physician signed Do Not Resuscitate (DNR) order, Health Care Proxy/Advanced Directive, or "File of Life".

Document Name _____ Location _____

Health Care Agent _____ Relationship _____

Contact #'s: Home _____ Work _____ Cell _____

Other Important Information

Note anything an outsider should be aware of including information about hearing, vision, memory, balance, walking, getting in/out of a chair or car, etc. If the elder has a Personal Emergency Response Service (i.e., Lifeline), note where the activation button is located.

_____

_____

_____

_____

_____

Emergency Room Checklist

Items to bring with you:

- ✓ Medical Insurance Cards
- ✓ List of telephone and contact information on all doctors and health care providers (Primary Care, Specialists, Home Health providers)
- ✓ List of all medications including over the counter, prescriptions and any supplements
- ✓ Assistive/Adaptive devices such as hearing aides, glasses, dentures, cane or walker
- ✓ Comfortable clothing (ideally without metal fasteners/zippers in case MRI or CT is needed), nightgown/pajamas, warm socks and slippers
- ✓ List of telephone numbers of close family members, friends and neighbors
- ✓ Other: _____

Notify (family members, neighbors, friends):

Name _____
Relationship _____
Home # _____
Work # _____
Cell # _____

Name _____
Relationship _____
Home # _____
Work # _____
Cell # _____

Name _____
Relationship _____
Home # _____
Work # _____
Cell # _____

Name _____
Relationship _____
Home # _____
Work # _____
Cell # _____

Services to suspend/cancel:

	Telephone # and/or Website
Newspaper	_____
Mail delivery	_____
Meal/Food delivery	_____
In Home Services	_____
Cleaning	_____
Home Health Care	_____
Other:	_____
Other:	_____

Note: Check calendar to see if there are appointments that need to be canceled

_____

_____

_____

Name: _____ Date of Birth: _____

Person(s) able to make Medical, Legal and Financial Decisions in Elder's Stead

Health Care Proxy/Agent

Person authorized to make decisions on medical treatment in the event of mental incapacity

Name _____ Relationship _____
Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____
Home # _____ Work # _____
Cell # _____ Email address _____
Contact Instructions _____

Document on file with Physician (s):
Name _____ Phone # _____
Name _____ Phone # _____

Physician signed Do Not Resuscitate (DNR) Order on File? ❑ Yes ❑ No
DNR Order states there be no medical intervention to restore cardiac or respiratory function should either fail.

Power of Attorney (POA)

Durable? ❑ Yes ❑ No

POA – Legal authorization to handle the personal and financial affairs of another.
Durable POA- Remains in effect in the event of mental incapacity.

Name _____ Relationship _____
Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____
Home # _____ Work # _____
Cell # _____ Email address _____
Contact Instructions _____
Document location _____

Conservator or Representative Payee

Conservator – Court appointed person to handle the financial affairs of one deemed mentally incompetent.
Representative Payee – Person authorized to receive an elder's Social Security check for bill paying purposes.

Name _____ Relationship _____
Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____
Home # _____ Work # _____
Cell # _____ Email address _____
Contact Instructions _____
Document on file with _____

Guardian

Court appointed person to handle the personal and financial matters of one deemed mentally incompetent.

Name _____ Relationship _____
Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____
Home # _____ Work # _____
Cell # _____ Email address _____
Contact Instructions _____
Document on file with _____

Name: _____ Date of Birth: _____

Home Emergency Information

Address _____ Apt# _____ Phone # _____

Landlord _____ Phone # _____

Property Manager _____ Phone # _____

Emergency Contact _____ Phone # _____

Neighbor _____ Phone # _____

Police _____ Fire _____ Ambulance _____

Fire Extinguisher Location _____ Flashlight _____

Alarm Company _____ Code Clue _____

Special Instructions _____

Circuit Breaker/Fuse Box Location _____

Water Valve Shut Off _____

Home Maintenance

Plumber _____ Phone # _____

Electrician _____ Phone # _____

A/C Heating _____ Phone # _____

Handy/Repair Person _____ Phone # _____

Snow Removal _____ Phone # _____

Gardener/Landscaper _____ Phone # _____

Other _____ Phone # _____

Utility Companies

Service	Company Name	Phone #	Account #
Electric			
Gas/Propane			
Oil			
Telephone			
Cable/Internet			
Other			

Name: ______________________________ Date of Birth: ______________

Important Personal Contacts

For important correspondence, list important personal contacts such as relatives, neighbors, and friends (former classmates, co-workers, etc). "If something happened and you were in the hospital, who would you want me to call?"

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
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Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Name ______________________
Relationship ______________________
Address ______________________
City, State & Zip ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________

Month _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
❑	❑	❑	❑	❑	❑	❑
❑	❑	❑	❑	❑	❑	❑
❑	❑	❑	❑	❑	❑	❑
❑	❑	❑	❑	❑	❑	❑
❑	❑	❑	❑	❑	❑	❑

Notes/To Do _____

Name: ______________________________ Date of Birth: ______________

Caregiver Information

Primary Caregiver

Name ______________________
Relationship ______________________
Address ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________
Visits via ☐ In Person ☐ Phone ☐ Email
Frequency of visits ______________________

Assistance Provided:
☐ Personal Care
☐ Medication ☐ Set up ☐ Prompting ☐ Administration
☐ Meal Prep. ☐ Breakfast ☐ Lunch ☐ Dinner
☐ Shopping
☐ Transportation
☐ Medical Appointments
☐ Bill Paying/Money Management

Other Informal (unpaid) Caregivers

Name ______________________
Relationship ______________________
Address ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________
Visits via ☐ In Person ☐ Phone ☐ Email
Frequency of visits ______________________

Assistance Provided:
☐ Personal Care
☐ Medication ☐ Set up ☐ Prompting ☐ Administration
☐ Meal Prep. ☐ Breakfast ☐ Lunch ☐ Dinner
☐ Shopping
☐ Transportation
☐ Medical Appointments
☐ Bill Paying/Money Management

Name ______________________
Relationship ______________________
Address ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________
Visits via ☐ In Person ☐ Phone ☐ Email
Frequency of visits ______________________

Assistance Provided:
☐ Personal Care
☐ Medication ☐ Set up ☐ Prompting ☐ Administration
☐ Meal Prep. ☐ Breakfast ☐ Lunch ☐ Dinner
☐ Shopping
☐ Transportation
☐ Medical Appointments
☐ Bill Paying/Money Management

Name ______________________
Relationship ______________________
Address ______________________
Home # ______________________
Work # ______________________
Cell # ______________________
Email ______________________
Visits via ☐ In Person ☐ Phone ☐ Email
Frequency of visits ______________________

Assistance Provided:
☐ Personal Care
☐ Medication ☐ Set up ☐ Prompting ☐ Administration
☐ Meal Prep. ☐ Breakfast ☐ Lunch ☐ Dinner
☐ Shopping
☐ Transportation
☐ Medical Appointments
☐ Bill Paying/Money Management

Religious/Cultural Organization

Name ______________________
Address ______________________
Phone ______________________ Contact ______________________
Frequency of visits ______________________ Visits ☐ In Person ☐ By Phone
Assistance provided ______________________

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Questions? Call us at 617-926-4100 or visit us on the web: www.springwell.com

Name: _____ Date of Birth: _____

Detailed Caregiver Information

Name _____ Relationship _____
Address _____
Home #_____ Work #_____ Cell #_____
Contact Instructions _____ Email _____

Visits via How Often

- ☐ In Person _____
- ☐ Phone _____
- ☐ Email _____

Type of Assistance Provided

Personal Care Frequency of Assistance/Notes

- ☐ Bathing _____
- ☐ Dressing _____
- ☐ Grooming (hair, teeth) _____
- ☐ Walking/Mobility _____
- ☐ Lifting/Transferring _____
- ☐ Toileting _____
- ☐ Eating _____

Medications

- ☐ Setting up pill box _____
- ☐ Prompting to take _____
- ☐ Helping to take _____

Household Management

- ☐ Meal Preparation _____
- ☐ Food Shopping _____
- ☐ Light Housework _____
- ☐ Laundry _____

Personal Management

- ☐ Transportation _____
- ☐ Shopping/Errands _____
- ☐ Medical Appointments _____
- ☐ Mail/Correspondence _____
- ☐ Banking/Bill Payment _____

Home Management

- ☐ Fix It/Repair _____
- ☐ Lawn Care _____
- ☐ Snow Removal _____
- ☐ Automobile Care _____

Other Assistance

_____ _____
_____ _____

Name: _____ Date of Birth: _____

Professional Service Providers

Skilled Nursing and Rehabilitation (*Physical, Speech, Occupational)* Therapies

Agency Name _____ www. _____

Address _____

Phone # _____ Contact _____

Days/Hrs _____ After Hours Contact _____

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Personal Care and Homemaking Services

Agency Name _____ www. _____

Address _____

Phone # _____ Contact _____

Days/Hrs _____ After Hours Contact _____

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Other Providers (Emergency Response Service, Care Coordinator, Delivered Meals, Day Program, Transportation, etc.)

Agency Name _____ www. _____

Address _____

Phone # _____ Contact _____

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Agency Name _____ www. _____

Address _____

Phone # _____ Contact _____

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Name: ______________________________ Date of Birth: ______________

Other Providers (Emergency Response Service, Care Coordinator, Delivered Meals, Day Program, Transportation, etc.)

Agency Name ______________________________ www. ______________

Address ______________________________

Phone # ______________________________ Contact ______________

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Agency Name ______________________________ www. ______________

Address ______________________________

Phone # ______________________________ Contact ______________

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Agency Name ______________________________ www. ______________

Address ______________________________

Phone # ______________________________ Contact ______________

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Agency Name ______________________________ www. ______________

Address ______________________________

Phone # ______________________________ Contact ______________

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Agency Name ______________________________ www. ______________

Address ______________________________

Phone # ______________________________ Contact ______________

Service	Frequency	Days/Times	Name	Paid for By	Start Date	End Date

Name: _____ Date of Birth:_____

About the Elder

The following is to help an outside caregiver learn about your loved one's likes, dislikes and important information about their life and day-to-day activities.

Prefers to be called (Mr/Mrs/Miss, Nickname) _____

First Language _____ Other languages spoken _____

Important Social History (schooling, career, membership organizations, etc.)

_____

_____

_____

Important Relationships (close relatives and friends)

Name Relationship Town Type and Frequency of contact

_____

_____

_____

Enjoys spending time by (social activities, etc.) _____

_____

Favorite places to go (restaurants, museums, parks, etc.) _____

_____

Favorite Pastimes (be as specific as possible and attach additional pages if necessary)

Hobbies Games Songs/Music TV Shows Radio Station

_____

_____

_____

Topics of interest (current events, sports, history, etc.)

_____

_____

Food & Snack preferences and dislikes

_____

_____

_____

Pet(s) Name Feeding Instructions Special Instructions

_____

_____

Daily Routine Overview

Wakes up at	
Breakfast	
Morning Routine	
Lunch	
Afternoon Routine	
Dinner	
Before Bed	
Bedtime	

Name: _____ Date of Birth: _____

Elder's Self-Care Abilities & Needs

Date _____

As you fill this out, think about whether you are comfortable with your loved one seeing your assessment of their abilities. If not, consider using it as an opportunity to discuss your concerns with them.

Personal Care

	Independent	w/Assistance (Describe)		Unable
Bathing	☐	☐	_____	☐
Dressing	☐	☐	_____	☐
Grooming (hair, teeth)	☐	☐	_____	☐
Eating	☐	☐	_____	☐
Walking/Mobility	☐	☐	_____	☐
Toileting	☐	☐	_____	☐
Medications	☐	☐	_____	☐

Household Management

	Independent	w/Assistance (Describe)		Unable
Meal Preparation	☐	☐	_____	☐
Food Shopping	☐	☐	_____	☐
Light Housework	☐	☐	_____	☐
Laundry	☐	☐	_____	☐
Transportation	☐	☐	_____	☐
Mail	☐	☐	_____	☐
Bill/Money Management	☐	☐	_____	☐

Adaptive Devices/Equipment

Item	Description	Repair/Supply Vendor Info
Glasses	_____	_____
Hearing Aid	☐ Left ☐ Right	_____
False Teeth/Bridge	☐ Partial ☐ Upper ☐ Lower	_____
Arm Brace	☐ Left ☐ Right	_____
Leg Brace	☐ Left ☐ Right	_____
Orthodic	☐ Inserts ☐ Shoes	_____
Cane	☐ Straight ☐ Pronged	_____
Walker	☐ w/ or w/o wheels ☐	_____
Wheelchair	☐ Standard ☐ Electric	_____
Other	_____	_____
Other	_____	_____

Notes _____

Name: _____ Date of Birth: _____

Daily Activity Log

Use this sheet to write down the day's activities. This will help other caregivers, family members or visitors know specifics about the elder's day such as what foods they ate, where they went, who called or visited. The notes can be brief or detailed.

Date _____

Breakfast	
Morning	
Lunch	
Afternoon	
Dinner	
Evening	

Above notes written by _____

Name: _____ Date of Birth: _____

MEDICATIONS, OVER THE COUNTER AND DIETARY SUPPLEMENTS:

Where meds are kept _____ Pill Boxes used? ☐ Yes ☐ No Person responsible for filling Pill Boxes _____

Name	Form	Dosage	For	Began	End	M.D. & Pharmacy	Notes
Sneeze Away	*Pill*	*1 50 mg 2x/day*	*Allergies*	*1/1/97*		*Smith/Rexall*	*Take with food*

Pharmacy _____

Address _____ City _____

Phone _____ Fax _____

Days/Hours _____ Website _____

Login ID _____ Password _____

Allergy Information

Drug Reaction First Occurred Treatment

_____

_____

_____

Name: ____ Date of Birth: ____________________

Health Log

Date	Time	Weight	Blood Pressure	Blood Sugar	Notes

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Name: _____ Date of Birth: _____

Medical Information

Medical Diagnoses

Diagnosis	Date given	Doctor	Treatment/Status

Surgeries and Procedures

Date	Surgeon	Hospital	Complications, if any

Hospitalizations and Rehabilitation Stays

Date	Hospital	Reason	Discharge Date	Discharged To

Name: _____ Date of Birth: _____

Important Medical Events (heart attack, seizure, fall, surgery, ER/Hospitalization, Rehab stay, etc.)

Date	Event	Treating Physician	Hospital/Facility	Admitted	Reason	Discharged	Notes

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Name: ____ Date of Birth:____________________

Important Tests (blood, CAT scan, X-Ray, MRI, etc)

Date	Description	Ordered By	Phone #	Test Results	Results kept

Name ______________________________ Date of Birth ______________

Physicians

Primary Care

Name ______________________________

Address ______________________________

Phone # ______________ Pager # ______________

Days/Hrs ______________ After Hours Instructions ______________

Fax # ______________ Email Address ______________

Hospital Affiliation (s) ______________________________

Specialty Physician Start Date ______________ End Date______________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________ Pager # ______________

Days/Hrs ______________ After Hours Instructions ______________

Fax # ______________ Email Address ______________

Hospital Affiliation (s) ______________________________

Specialty Physician Start Date ______________ End Date ______________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________ Pager # ______________

Days/Hrs ______________ After Hours Instructions ______________

Fax # ______________ Email Address ______________

Hospital Affiliation (s) ______________________________

Specialty Physician Start Date ______________ End Date ______________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________ Pager # ______________

Days/Hrs ______________ After Hours Instructions ______________

Fax # ______________ Email Address ______________

Hospital Affiliation (s) ______________________________

Name ______________________________ Date of Birth ____________

Additional Specialty Physicians

Specialty Physician Start Date ____________ End Date ____________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________________ Pager # ______________________

Days/Hrs ______________________ After Hours Instructions ______________

Fax # ______________________ Email Address ______________________

Hospital Affiliation (s) ______________________________

Notes ______________________________

Specialty Physician Start Date ____________ End Date ____________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________________ Pager # ______________________

Days/Hrs ______________________ After Hours Instructions ______________

Fax # ______________________ Email Address ______________________

Hospital Affiliation (s) ______________________________

Notes ______________________________

Specialty Physician Start Date ____________ End Date ____________

Name ______________________________

Specialty ______________________________

Hospital/Clinic ______________________________

Phone # ______________________ Pager # ______________________

Days/Hrs ______________________ After Hours Instructions ______________

Fax # ______________________ Email Address ______________________

Hospital Affiliation (s) ______________________________

Notes ______________________________

Name ______________________________ Date of Birth ____________

Other Medical/Health Professionals

Use this page to note other health professionals such as Chiropractor, Dentist, Ophthalmologist, Optometrist, Audiologist, and Podiatrist. After their name, write the type of care they provide.

Name ______________________________

Address ______________________________

Phone # ______________ Fax # ______________

Days/Hrs ______________ After Hours Instructions ______________

Pager # ______________ Web/Email Address ______________

Name ______________________________

Address ______________________________

Phone # ______________ Fax # ______________

Days/Hrs ______________ After Hours Instructions ______________

Pager # ______________ Web/Email Address ______________

Name ______________________________

Address ______________________________

Phone # ______________ Fax # ______________

Days/Hrs ______________ After Hours Instructions ______________

Pager # ______________ Web/Email Address ______________

Name ______________________________

Address ______________________________

Phone # ______________ Fax # ______________

Days/Hrs ______________ After Hours Instructions ______________

Pager # ______________ Web/Email Address ______________

Name ______________________________

Address ______________________________

Phone # ______________ Fax # ______________

Days/Hrs ______________ After Hours Instructions ______________

Pager # ______________ Web/Email Address ______________

Name: _____ Date of Birth: _____

Call Log

Date/Time	Notes = Spoke with, Agency Name, Phone#, What was discussed	To Do?

Name: _____ Date of Birth: _____

Upcoming Doctor Visit

Appointment Date _____ Time _____

Doctor's Name _____ Specialty _____

Office/Clinic Location _____ Phone _____

Reason for visit (current symptoms) _____

Remember to bring: _____

Questions/Concerns to discuss

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Additional Notes _____

_____

_____

_____

_____

Tests Done Results/Call for results

_____

_____

Outcome - Diagnosis and Next Steps

Diagnosis _____

Additional Tests Treatment Scheduled for What to Expect

_____

_____

Medication Changes

_____

_____

_____

Follow Up Appointment Date and Time _____ Remember to bring _____

Other Notes: _____

_____ Above notes written by _____

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Name: _____ Date of Birth: _____

Location of Key Documents - CONFIDENTIAL

Document	Location	Date Noted
Social Security Card		
Medicare Card		
Secondary Health Insurance Card		
Health Care Proxy		
Living Will/Advance Directive		
Power of Attorney		
Guardianship		
Conservator/Representative Payee		
Life Insurance Policy(s)		
Will		
Trust Information		
Military ID/Papers		
Real Estate Property Deeds		

Bank and other Financial Documents

Note: Specify Name of Bank, Financial Institution or Company

Document	Location	Date Noted
Loan Documents		
Annuity Contracts		
Stock Certificates/Bonds		

Bank Vault/Safe Deposit Box (es)

Bank Location _____ Date _____
Box # _____ Location of Key _____
Add'l Name/Signatures on file _____

Bank Location _____ Date _____
Box # _____ Location of Key _____
Add'l Name/Signatures on file _____

Name: _____ Date of Birth: _____

Legal, Investment and Accounting Contacts

Attorney

Name _____
Firm Name _____ www. _____
Address _____ City _____ State___ Zip _____
Office Phone _____ Cell Phone _____
Email _____ Assistant's name _____
Office Hours _____

Financial Advisor/Planner

Name _____
Firm Name _____ www. _____
Address _____ City _____ State___ Zip _____
Office Phone _____ Cell Phone _____
Email _____ Assistant's name _____
Office Hours _____

Stock Broker/Investment Consultant

Name _____
Firm Name _____ www. _____
Address _____ City _____ State___ Zip _____
Office Phone _____ Cell Phone _____
Email _____ Assistant's name _____
Office Hours _____

Accountant/Tax Advisor

Name _____
Firm Name _____ www. _____
Address _____ City _____ State___ Zip _____
Office Phone _____ Cell Phone _____
Email _____ Assistant's name _____
Office Hours _____

Other _____

Name _____
Firm Name _____ www. _____
Address _____ City _____ State___ Zip _____
Office Phone _____ Cell Phone _____
Email _____ Assistant's name _____
Office Hours _____

Name: _____ Date of Birth: _____

Insurance

Home

Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Automobile

Car 1 Make _____ Model _____ Year _____
Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Car 2 Make _____ Model _____ Year _____
Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Life

Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Disability

Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Long Term Care

Policy# _____
Agent Name _____ Phone # _____
Agency Name _____ www._____
Address _____ City _____ State___ Zip _____
Insurance Company/Underwriter_____www._____
24 Hour Claim Phone # _____

Name: _____ Date of Birth:_____

Banking Information - CONFIDENTIAL

Bank Name _____ www. _____
Address _____ City _____ State___ Zip _____
Phone _____ Branch where Acct was opened _____
Contact Person _____ Direct line _____
Email address _____ Branch Days/Hours _____
Checking Account # _____ Add'l Name on Acct _____
Savings Account # _____ Add'l Name on Acct _____
Money Market Account # _____ Add'l Name on Acct _____
On Line Banking Website_____ UserID _____ Password Clue _____
Certificates of Deposit

Term	Amount	Start Date	Maturity Date	Notes (auto rollover, etc.)

Bank Name _____ www. _____
Address _____City _____ State___ Zip _____
Phone _____ Branch where Acct was opened _____
Contact Person _____ Direct line _____
Email address _____ Branch Days/Hours _____
Checking Account # _____ Add'l Name on Acct _____
Savings Account # _____ Add'l Name on Acct _____
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On Line Banking Website_____ UserID _____ Password Clue _____
Certificates of Deposit

Term	Amount	Start Date	Maturity Date	Notes (auto rollover, etc.)

Name: _____ Date of Birth: _____

Income, Expenses and Net Worth – CONFIDENTIAL

Social Security # _____

Income

Social Security	$
Pension/Retirement	$
Annuities	$
Interest	$
Dividends	$
Rent	$
Other: _____	$
Other: _____	$
TOTAL	**$**

Expenses

Rent/Mortgage	$
Other Mortgage	$
Bank Loan	$
Income Tax (Qtrly)	$
Property Tax	$
Utilities	
Phone	$
Gas	$
Oil	$
Electric	$
Water	$
Cable	$
Groceries	$
Restaurants	$
Personal (hair, clothes)	$
Auto (gas, repair)	$
Other Transportation	$
Medical	$
Dental	$
House (landscaper, etc)	$
In Home Services	$
Other _____	$
Other _____	$
TOTAL	**$**

Assets (own)

Checking Account	$
Savings Account	$
CD's	$
Money Market Funds	$
Life Insurance (cash value)	$
Approximate Market Value of	
Pension Funds	$
Mutual Funds	$
Stocks	$
U.S Treasury (bills, bonds)	$
Real Estate Equity	$
Automobiles	$
Personal (Jewelry, Art, Furniture)	$
Other (boat, etc)	$
Other	$
TOTAL	**$**

Liabilities (owe)

Mortgage	$
Second Mortgage	$
Reverse Mortgage	$
Bank Loans	$
Car Loans	$
Credit Cards	$
Personal Loans	$
Other _____	$
TOTAL	**$**

Total Assets
Minus Total Liabilities

Total Assets	**$**
Minus Total Liabilities	**$**
NET WORTH	**$**

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Questions? Call us at 617-926-4100 or visit us on the web: www.springwell.com

Name: _____ Date of Birth: _____

Monthly Bills

Expense	Name	Account #	Phone #	Due Date
Rent/Mortgage				
Other Mortgage				
Bank Loan				
Credit Card				
Credit Card				
Credit Card				
Credit Card				
Gas/Auto Credit Card				
Gas (house)				
Oil				
Electric				
Phone				
Cellular Phone				
Trash Collection				
Cable/Internet				
Newspaper				
Other				
Other				

Notes

Quarterly Bills

Expense	Name	Account #	Phone #	Due Date
Property Tax				
Estimated Income Tax				
Water				
Other				
Other				

Notes

Name: _____ Date of Birth:_____

End of Life Instructions

End of Life discussions and decisions can be difficult. This page is to serve as a starting point in discussing and gathering the information. We encourage you to speak with the Primary Care Physician and call Springwell for more information and assistance with this complex topic. For detailed information on End of Life care and answers to frequently asked questions, go to www.endoflifecommission.org, or call 617-636-3480. To order a copy of "Five Wishes", a document to put your wishes on specific treatment and care in writing, go to: www.agingwithdignity.org or call 888-594-7437.

Health Care Proxy/Advance Directive completed? ☐ Yes ☐ No On File with Dr. _____

Includes the following requests:

☐ Do Not Hospitalize
☐ Do Not Tube Feed (*insertion of tube into stomach to provide nutrition*)
☐ Do Not Resuscitate (*revive heart or breathing*)
☐ Do Not Intubate (*insertion of a tube to assist breathing*)
☐ No Extraordinary Measures *(any effort to artificially sustain life when no hope of medical improvement exists)*
☐ Comfort Measures Only (*no intervention to prevent death and make physically as comfortable as possible*)

Health Care Agent _____ Relationship _____
Contact Instructions _____
Home # _____ Work # _____ Cell # _____

Family/Friend to be notified

Name _____ Relationship _____
Contact Instructions _____
Home # _____ Work # _____ Cell # _____

Name _____ Relationship _____
Contact Instructions _____
Home # _____ Work # _____ Cell # _____

Name _____ Relationship _____
Contact Instructions _____
Home # _____ Work # _____ Cell # _____

Attorney to be notified

Name _____ Firm Name _____
Address _____ City _____ State___ Zip _____
Phone # _____ Cell # _____

Clergy to be notified

Name _____ Phone #_____
Address _____ City _____ State___ Zip _____

Funeral Home_____
Address _____ City _____ State___ Zip _____
Phone # _____ ☐ Pre-Paid _____

Cemetery _____
Address _____ City _____ State___ Zip _____
Phone # _____ ☐ Pre-Paid Lot# _____

Other instructions _____

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Questions? Call us at 617-926-4100 or visit us on the web: www.springwell.com

Resources

Springwell, Inc.

617-926-4100
TTY: 617-923-1562
Fax: 617-926-9897
www.springwell.com
inforef@springwell.com

Medicare
http://www.medicare.gov/
800-633-4227

Medicaid - MassHealth
www.mass.gov/masshealth
800-841-2900

Social Security Administration
http://www.ssa.gov/
800-772-1213

Notes

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